LEONG CHIN KUM

v.

SELCO (SHIPYARD) PTE. LTD.

HIGH COURT, SINGAPORE
FA CHUA J
[SUIT NO. 2995 OF 1977]
31 AUGUST 1982

TORT: *Negligence - Death of employee during the course of employment - Whether there was breach of statutory duty - Knowledge of risk.*

The plaintiff the widow of the deceased brought an action against the defendants under the Civil Law Act (Cap.30) on behalf of herself and her child as dependants. The deceased, employed by the defendants as a project supervisor at their shipyard in Jurong, met his death during the course of his employment. The plaintiff alleged that the death of her husband resulted from negligence of the defendants, their servants or agents or breach of statutory duty.

On 4 October 1976 barge 222, owned by Prentis Davis was brought to the defendants' shipyard for a survey of the damage. The deceased was assigned to be in charge of the actual repair work. As there was a dispute as to the estimated costs to the inside of the barge a full internal inspection of the fatal central tank no. 5 was requested. The tank was located in a compartment of the barge and the floorboard of the compartment had to be removed to expose the manhole.

On the day in question the deceased was found directing the workers to open the manhole. As ventilation was required to circulate air into the tank, leaving the deceased alone, Davis went to look for a powered blower for the said purpose. On hearing a yell he returned to the compartment and saw the deceased lying in the tank. The cause of the death was said to be asphyxia and the external injuries were consistent with a fall from a low height. Four persons had entered the fatal tank and collapsed. Three of them died and the fourth person was hospitalised.

Held:

[1] The deceased knew that he needed the clearance of the safety promoter, that a powered blower was necessary to ventilate the tank and he knew that a powered blower was coming, yet he wilfully entered the tank alone with no one present in the compartment ignoring all the safety procedures adopted by the defendants in connection with entering a freshly opened tank which contained water and where extensive rusting had taken place.

[2] The employers were not in breach of any statutory duty and even if there was, there was no evidence that the breach caused or materially contributed to the death of the deceased.

[3] The accident was caused solely by the negligence of the deceased.

[Claim dismissed with costs.]

Case referred to:
Bonnington Castings Ltd. v. Wardlaw [1956] AC 613

For the plaintiff - H. Cashin
For the defendant - Tan Tee Seng

JUDGMENT

FA Chua J:

The plaintiff is the widow of Sylvester Jasper Monteiro, deceased. She brings this action on behalf of herself and her child as dependants of the deceased under the provisions of the Civil Law Act (Cap.30).

The deceased was employed by the defendants as a project supervisor at their shipyard at Jalan Samulan Jurong.

The deceased met his death during the course of his employment by the defendants on 5 October 1976. The plaintiff alleged that the deceased's death was caused by the negligence of the defendants, their servants or agents and/or by breach by the defendants as employers of the deceased to take reasonable care for the safety of the deceased as their servant and/or by breach by the defendants of their statutory duty under the Factories Act 1973.

The facts are these. On 4 October 1976, barge 222 was brought to the defendants' shipyard for a survey of the damage. The barge had been chartered and handed back to the owner, Prentis Davis. The deceased was assigned to the barge as project supervisor and was in charge of the actual repair work. Abdullah bin Abdul Wahid, the assistant shipyard manager, was in charge of the estimation of the costs of the repair of barge 222. On 4 October Abdullah surveyed the outside of the barge and did an estimate of the repairs to be done. Davis wanted to have the bottom plate of the barge renewed. Inside the barge where the plate was to be renewed was a tank - centre tank no. 5.

Abdullah handed the estimate to Davis on 5 October 1976. In the estimate was included an item of costs to the inside of the barge which Abdullah assumed had to be repaired. Davis disputed the estimate and requested a full internal inspection as well. That would involve the inspection of centre tank no. 5. The idea was that Abdullah and the deceased were to do this together in due course.

Centre tank no. 5 was located in a compartment of the accommodation part (called the *portacamp*) of the barge. The floorboard of the compartment had to be removed in order to expose the manhole.

According to Davis (DW1) it was in the afternoon of 5 October 1976 that the manhole of centre tank no. 5 was ultimately found. He entered the compartment, in the afternoon. There was work going on in the compartment. There were men with tools preparing to open the manhole. The deceased was there directing the workers in their work. After the manhole was opened Davis and the deceased looked into the tank. The deceased lowered an electric light into the tank and Davis observed that there was a bit of water at the bottom, and there was sign of rusting. Davis asked the deceased "where is the blower?" A powered blower is a fan worked by an electric motor and there is a duct in the fan which you can push into the tank to circulate air into the tank to ventilate it. The deceased did not reply and Davis left the compartment to see if there was anyone around with a powered blower. Davis said that when he left the compartment there was no one in the compartment with the deceased. Deceased was alone. Davis went outside the compartment and stood about three meters from the compartment expecting someone to come with the powered blower. Davis heard a yell and he returned to the compartment. He looked down into the tank and saw the deceased lying inside the tank.

Abdullah bin Abdul Wahid (PW4) said in evidence that he knew nothing until 5.30 p.m. on 5 October 1976 when he came to know that the manhole cover of centre tank no. 5 had been removed and that there had been an accident. He went to the barge. He looked into the centre tank no. 5 and saw the deceased lying at the bottom of the tank. He then went with a charge hand to the workshop to get the powered blower and brought it to the barge. At this stage he looked into the tank again and saw two more bodies. He put on the oxygen tank and mask to try to get down into the tank through the manhole. He found it difficult to get down because of one beam. He then went down a rung or two of the ladder leading to the bottom of the tank and the oxygen tank and mask were lowered to him and he strapped the oxygen tank on his back, put on the mask and went down the ladder. Even before he reached the bottom he felt that oxygen supply was being cut off. He managed to climb up the ladder four or five steps and he was hauled up and he lost consciousness.

Lee Yew Wah (DW2) an electrician employed by the defendants, said that he reported for duty on 5 October 1976, at 3.45 p.m. On instructions he went to barge 222 to install a lamp switch board and a powered blower. He went to the compartment where centre tank no. 5 was located. There he saw the deceased, Davis, carpenters and fitters. The carpenters were cutting open the board covering the tank and the fitters were waiting to unscrew the manhole. The deceased was directing the carpenters. After he had installed four lights in the compartment he told the deceased that he needed two men to assist him to bring the powered blower from the electrical department to the barge. The deceased said "OK" and he left. When he left the compartment the manhole was yet to be opened. He went back to the electrical department to prepare the powered blower and to wait for the two men. While he was waiting he heard the siren and saw many people rushing towards barge 222 and he learnt that someone had fallen into the tank.

In all four persons had entered centre tank no. 5 and collapsed. Three of them died and the fourth person was hospitalised.

At 9 p.m. on 5 October 1976, at the request of the police Phang Sing Eng, chief port chemist, boarded barge 222 to test the atmosphere of centre tank no. 5. There was about six to eight inches of water at the bottom of the tank. There was extensive rusting on the surface of the metal plates inside the tank. The chemist tested the atmosphere of the tank for oxygen content and for toxic gases. The oxygen content inside the tank varied from 8% at the bottom of the tank to 9% at the upper part of the tank. No toxic gases were detected. From the results obtained the chemist was of the opinion that "the accident was caused by the gross deficiency of oxygen content inside the tank in the rusting process in which the oxygen combined with the steel to form iron oxide (rust)."

An autopsy was performed on the body of the deceased. There was an abrasion on the deceased's right forehead 2 x 3 cm. and a bruise on the right mid shin 1½ x 1 cm. The doctor who performed the autopsy reported that the cause of death was asphyxia and said that the external injuries were consistent with a fall from a low height.

The deceased joined the defendants' shipyard in August 1969, as an assistant bench fitter. He was promoted to trainee technician in March 1971, and a technician on 1 January 1972.

The evidence of Abdullah (PW4) is that the work of a technician is the same as that of a project supervisor. He is given training on his job and all aspects of safety including the entry into a confined space, the use of oxygen mask, the wearing of safety belts and the proper use of safety equipments and ventilation. He is also told that he is not to go into a tank unless he gets a safety report from the safety promoter.

When a vessel arrives at the yard for repair a project supervisor is assigned to the vessel. He is the person in sole and complete charge of the repair of the vessel. He makes all the decisions including when to enter a confined space. He would liase with the heads of the various departments regarding the repair jobs that have to be done.

If the work entails entry into a tank or confined space he would, after he had issued the work orders, personally go to the machinery department to get the fitters to open the manhole first. Then he would go to the electrical department to arrange for lighting and powered blower. He will tell them which is the place to be ventilated and where to put the lights. Then he would go to the safety promoter assigned to the vessel and ask him to check the tanks for gases. The safety promoter would check the tank and submit a report to the project supervisor. The report will state whether the tanks are gas free or not and the ventilation to be provided.

In this instance the gas detection report of the safety promoter (AB14) was addressed to the deceased and signed by the Abu Bakar bin Omar, one of the persons who collapsed in centre tank no. 5 and who subsequently died. The report stated that four tanks port, four tanks starboard and one tank centre was examined and found to be gas free. The one tank centre that was examined was not centre tank no. 5 but centre tank no. 6 and the examination was made on 4 October 1976. The safety promoter expressed the view that the tanks examined were free from flammable vapours and he made the remarks: "confirmed fit for hot works, adequate ventilation should be provided during process."

The evidence of Abdullah (PW4) as to the remarks of the safety promoter in AB14 is this:

> It means it is safe for workers to do hot works in the tank provided ventilation is provided during the process. 'Hot works' means involve use of fire, acetylene torch, etc. If no hot works is to be done it would be safe to go into the tank. If no hot works is to be done you don't require ventilation, according to this report. Before such a report is issued the safety promoter, as a matter of procedure, would inspect the tank for gas free and ventilating and when he is satisfied then such a report would be issued...

This report is really a clearance from the safety promoter that it was safe to enter the tank. This was the procedure in the yard. A project supervisor would not enter a tank without such a report. "To my knowledge no project supervisor had entered into a tank without such a report."

The last person to see the deceased alive was Davis. It is clear that the deceased could not have fallen into the tank accidentally. The deceased must have entered the tank by himself. The other persons who collapsed in the tank had entered the tank later in an attempt to rescue the deceased.

The deceased was a very experienced project supervisor. The deceased knew that he needed the clearance of the safety promoter, that a powered blower was necessary to ventilate the tank and he knew that a powered blower was coming, yet he wilfully entered the tank alone with no one present in the compartment ignoring all the safety procedures adopted by the defendants in connection with entering a freshly opened tank which contained water and where extensive rusting had taken place.

As to the allegation that the employers were in breach of statutory duty, I find on the facts of this case that there is no substance in any of the complaints. Even if there is substance in any of them there is no evidence that the breach caused or materially contributed to the death of the deceased. [See *Bonnington Castings Ltd. v. Wardlaw* [1956] AC 613]

This accident was caused solely by the negligence of the deceased. The claim of the plaintiff is dismissed with costs.

Also found at [1982] CLJ 481